MICHAEL C. TOMS, DDS, MS
Implant Dentistry & Periodontics

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.

Name: _____ Today's Date: _____

Home Address: _____

Home/Cell Phone_____ Date of Birth: _____

Email: _____ Social Security Number: _____

Height _____ Weight _____ Gender _____ Marital Status (Please Circle): ☐ Married ☐ Single ☐ Other

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Physician: _____ Phone: _____

Address:_____

Last Physical Examination Date: _____

Primary Dentist: _____ Phone: _____

Address:_____

Dental Insurance Information: Only if this has changed since last visit

Subscriber's Name: _____ Subscriber's Phone Number: _____

Subscriber's Date of Birth: _____ Subscriber's SS Number: _____

Employer Name: _____ Employer Phone Number: _____

Insurance Company Name: _____ Insurance Phone Number: _____

Member ID Number: _____ Insurance Group Number: _____

Medical History (Circle One)

☐ Yes No ☐ Are you now under the regular care of a physician?
If so, for what? _____

☐ Yes No ☐ Have you had any major operations, hospitalization or illnesses?
If so, for what? _____

☐ Yes No ☐ Are you taking any pills, medication or drugs? If so, please list

_____

_____

_____

☐ Yes No ☐ Are you required to take a pre-medication before any dental work?

☐ Yes ☐ No Are you taking bisphosphonates? *(ie: Fosamax, Boniva, Reclast)* _____

☐ Yes ☐ No Are you taking any vitamins or herbal medications? _____

☐ Yes ☐ No Do you smoke? How Much? _____ How Often? _____

☐ Yes ☐ No Do you drink alcohol? How Much? _____ How Often? _____

☐ Yes ☐ No Have you ever had any problems with surgery or anesthesia?

Have you ever had a reaction to the following: (Please Check)

☐ Penicillin ☐ Sleeping pills (barbiturates)
☐ Sulfa Drugs ☐ Tetracycline
☐ Codeine ☐ Dental anesthetic
☐ Aspirin ☐ Nitrous Oxide(laughing gas)
☐ Bisphosphonates ☐ Latex

Other Allergies: _____

Do you have or have you ever had: (Please Check)

☐ Rheumatic fever
☐ Heart murmur/mitral valve prolapse
☐ Heart Attack
☐ Arteriosclerosis
☐ Diabetes
☐ Stroke
☐ AIDS/HIV+
☐ Anemia/Hemophilia/blood disorder
☐ Tumors and growths
☐ Radiation therapy/Chemotherapy
☐ Artificial heart valves
☐ Frequent Headaches
☐ Jaw Pain
☐ Artificial Joints
☐ Psychiatric care
☐ Pregnant
☐ Frequent fractures or dislocations
☐ Condition requiring cortisone/steriods
☐ Hepatitis, jaundice, or other liver disease
☐ Osteoporosis
☐ Ulcers (stomach or duodenal)
☐ Kidney or bladder trouble
☐ High or low blood pressure
☐ Thyroid disease
☐ Back problems
☐ Asthma or difficulty breathing
☐ Herpes
☐ Chemical dependency
☐ Arthritis or rheumatism
☐ Painful or swollen joints
☐ Rash or skin disorders
☐ Dizziness or light headedness
☐ Sinus problems
☐ Depression
☐ Sexually related disease
☐ Shortness of breath or chest pains upon exertion
☐ Birth Control Medication
☐ Cancer
☐ Tuberculosis, COPD, emphysema, lung disease
☐ Food Allergies: _____

Do you have any disease, condition, or problem not listed above that you think I should know about?

If so, what? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change, I will inform the doctor. I understand that this information will be used by dentist to help determine appropriate and healthful dental treatment.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid by insurance or not.

Signature: _____ Date: _____